

USAF REFRACTIVE SURGERY APPLICATION - Civilian Treatment									
This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) https://kx.afms.mil/USAF-RS or Public Access http://airforcemedicine.afms.mil/USAF-RS									
Application Date:									
APPLICANT INFORMATION					AASD PERSONNEL ONLY				
Last Name		First Name		Middle Initial	Actively Fly <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Aircraft of Assignment		
SSN (last 4)		DOB		Age	Crew/Duty Position			Aviation Service Code (ASC)	
Grade/Rank		Primary AFSC		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Total # of Military Flying Hours			Total # of Flying Hours in Last 6 Month	
Duty Status <input type="checkbox"/> AD <input type="checkbox"/> AGR <input type="checkbox"/> AFRes <input type="checkbox"/> ANG <input type="checkbox"/> Other		MAJCOM			FLIGHT SURGEON CONTACT INFORMATION				
Total # months of remaining AD retainability (eligible for elective surgery benefits)					Unit/Squadron & Office Symbol			Phone (DSN)	
NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.					Street				
Unit/Squadron & Office Symbol				Phone (DSN)	Base / State Zip + 4				
Street					Duty E-mail				
Base / State Zip + 4					Flight Surgeon's Name/Rank				
Duty E-mail					Flight Surgeon's Signature				
REFRACTIVE SURGEON CONTACT INFORMATION									
Refractive Surgery Center									
Street					City / State Zip + 4				
Refractive Surgeon's Name					Phone:		FAX:		
MANDATORY QUESTIONS (APPLICANT MUST INITIAL)									
Initials		I understand that I am responsible for reading and am required to comply with the policy and guidelines of the USAF Refractive Surgery (USAF-RS) Program available on the AF Knowledge Exchange (DotMil) https://kx.afms.mil/USAF-RS or Public Access http://airforcemedicine.afms.mil/USAF-RS							
Initials		I understand I am NOT authorized to schedule or undergo refractive surgery until I have received "Permission to Proceed" from the appropriate USAF-RS Program Manager. If granted "Permission to Proceed", the final treatment decision is not guaranteed, but will be made by the surgeon.							
Initials		I understand that if my commander endorses this request for refractive surgery, the authorization is only valid for a period of 6 months from the date of the commander's signature. I understand I must obtain a new commander's authorization if I am unable to complete refractive surgery within the 6 months period. I understand I must present an original, signed, and valid commander's authorization to the treatment center before I will be treated.							
Initials		I must inform my flight surgeon, primary care provider, and eye care provider of surgery, follow-up care, and any complications. I must accomplish all follow-up examinations as required by policy or I may be restricted from duty or be DNIF until in compliance.							
Initials		I understand that during my evaluation at a RS center, I may be disqualified as a RS candidate and will not be treated. The final decision will be made by my surgeon.							
Initials		If I am disqualified as a RS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the RS center, including, but not limited to travel, meals, and lodging.							
Initials		I understand that I may require or continue to require reading and/or distance prescription correction for best vision after surgery. I understand that RS will create a permanent change in my vision and even with an optimal outcome may change over time.							
Initials		I understand my vision may take time to fully recover following RS Surgery and there is a risk of not meeting relevant vision standards after RS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.							
Initials		Furthermore, I understand there is a chance I cannot be fit with contact lenses after RS.			Applicant's Signature				
Mail/E-Mail application and all supporting documents to:					USAF-RS PROGRAM MANAGER REVIEW USE ONLY				
USAFSAM/FECO WRIGHT-PATTERSON AFB, OH					<input type="checkbox"/> APM (AASD) <input type="checkbox"/> WPM (Warfighter)				
E-Mail USAFSAMAircrewProgramManager@wpafb.af.mil					Disposition Date		Permission to Proceed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Voice: (937) 938-2684 / 2676 DSN 798-2684 / 2676									
JOINT WARFIGHTER REFRACTIVE SURGERY CENTER									
2201 BERQUIST DRIVE, STE 1					E-Mail WHMC-CRS@lackland.af.mil				
Attn: 59 SSS / SG02ER (WF Pkts)					FAX: (210) 292-2813 / DSN 554-2813				
LACKLAND AFB, TX 78236-9908					Voice: (210) 292-3495 / DSN 554-3495				
USAF: Civilian Refractive Surgery Application (Page 1 of 2), 28 JUL 2011					Reviewing Officer's Name/Rank				
					Reviewing Officer's Signature				

USAF REFRACTIVE SURGERY APPLICATION - Civilian Treatment APPLICANT'S OCULAR/REFRACTIVE STATUS (TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)									
Evaluation Date				"Current" refractive status data must be < 6 MONTHS OLD					
Last Name			First Name			Middle Initial		SSN (last 4)	
Uncorrected Visual Acuity				Pupil Size (indicate method used)			Contact Lens Wear History		
OD 20 / OS 20 / OD OS				OD OS mm mm <input type="checkbox"/> Infrared Pupilometry (lights off) <input type="checkbox"/> Humphrey Visual Field (lights off) <input type="checkbox"/> PD Ruler (min light to see pupils) <input type="checkbox"/> Other			Type Worn <input type="checkbox"/> N/A <small>How many days since last worn?</small> <input type="checkbox"/> SCL <input type="checkbox"/> RGP Prior to any evaluation/CRS treatment - contact lens use must be discontinued. <div style="background-color: #ffff00; padding: 2px;"> SCL for minimum 30 days. HCL / RGP for minimum 90 days </div>		
Pachymetry (if available locally)									
OD OS microns microns									
Prior Manifest Refraction			Date:			Patient to fill out:			
Must be >12 months prior to current exam						CONTRAINDICATIONS / WARNINGS			
OD OS X X 20 / 20 /			Age < 21 <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant /Nursing during last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Severe dry eyes / atopic disease <input type="checkbox"/> Yes <input type="checkbox"/> No Electronic Pacemaker/similar cardiac device <input type="checkbox"/> Yes <input type="checkbox"/> No Autoimmune disease / immunodeficiency Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No Dermatitis Herpetiformis <input type="checkbox"/> Yes <input type="checkbox"/> No Pemphigus Vulgaris <input type="checkbox"/> Yes <input type="checkbox"/> No Vitiligo <input type="checkbox"/> Yes <input type="checkbox"/> No Current use of: Accutane (Isotretinoin) <input type="checkbox"/> Yes <input type="checkbox"/> No Imitrex (Sumatriptan) <input type="checkbox"/> Yes <input type="checkbox"/> No Cordarone (Amiodarone) <input type="checkbox"/> Yes <input type="checkbox"/> No Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No INH <input type="checkbox"/> Yes <input type="checkbox"/> No						
MANIFEST REFRACTION TO BEST VISUAL ACUITY									
OD OS X X 20 / 20 /									
CYCLOPLEGIC REFRACTION TO 20/20 VISUAL ACUITY									
OD OS X X 20 / 20 /									
KERATOMETRY				Check box if Irregular Mires					
OD OS @ @ @ @				<input type="checkbox"/> <input type="checkbox"/>					
CORNEAL TOPOGRAPHY				Explain Abnormal					
OD <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal OS <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal									
ORB SCAN				Explain Abnormal					
OD <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal OS <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal									
SLIT LAMP EXAM				Explain Abnormal in comment box					
OD <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal IOP OS <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal IOP mmHg mmHg									
DILATED FUNDUS EXAM				Explain Abnormal					
OD <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal OS <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal									
ASSESSMENT / PLAN									
COMMENTS									
Examiner's Name/Title:			Phone:			Fax:			